*The Future of …*

# Iowa's Health and Long-Term Care Workforce



The Health and Long-Term Care Workforce Review and Recommendations

**Preliminary Report**
for the
Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

October 2007
Iowa Department of Public Health

(Projected release of final report – December 19, 2007)

**"People are a vital ingredient in the strengthening of health systems. But it takes a considerable investment of time and money to train health workers. That investment comes both from the individuals and from institutional subsidies or grants. Countries need their skilled workforce to stay so that their professional expertise can benefit the population. When health workers leave to work elsewhere, there is a loss of hope and a loss of years of investment."**

-- Dr. LEE Jong-wook, Director-General, World Health Organization, opening message for the World Health Report 2006

## Table of Contents

*The final report will include a table of contents.*

This report is in partial fulfillment of House File 909 enrolled by the 2007 session of the Iowa Legislature:

Sec. 110. HEALTH AND LONG-TERM-CARE WORKFORCE REVIEW AND RECOMMENDATIONS.

1. The department of public health, in collaboration with the department of human services, the department of inspections and appeals, the department of workforce development, and other state agencies involved with relevant health care and workforce issues, shall conduct a comprehensive review of Iowa's health and long-term-care workforce. The review shall provide for all of the following:
   a) Raising of public awareness of the imminent health and long-term-care workforce shortage, based upon the rapidly changing demographics in the state.
   b) A description of the current health and long-term-care workforce, including documenting the shortages and challenges that exist throughout the state and analyzing the impact of these shortages on access to care, the quality of care received including outcomes, and the cost of care.
   c) A projection of the health and long-term-care workforce necessary to provide comprehensive, accessible, quality, and cost-effective care during the next twenty-five years.
   d) Construction of a workforce model to provide the necessary or desirable health and long-term-care workforce described in paragraph "c".

2. The department of public health and other agencies collaborating in the review shall actively elicit input from persons involved or interested in the delivery of health and long-term-care services, including but not limited to members of the health and long-term-care workforce and consumers of health and long-term care.

3. The department shall coordinate the review with other initiatives such as PRIMECARRE and the Iowa collaborative safety net provider network recruitment effort.

4. The department of public health shall submit the findings and recommendations of the review for submission to the general assembly and the governor on or before January 15, 2008. The recommendations shall include specific action steps to assist the state in meeting the health and long-term-care workforce shortages and challenges. The action steps shall include but are not limited to all of the following:
   a) Strategies such as enhanced pay and benefits, expanded initial and ongoing training, flexible work scheduling, reduced workload volume, and utilizing a team-based approach to providing care to both recruit and retain the necessary health and long-term-care workforce.
   b) Utilization of innovative measures, including but not limited to telemedicine and other emerging technologies, and scope of practice changes that allow modifications in roles and responsibilities in various health and long-term-care settings.

## Executive Summary

*The final report will include an executive summary – organization planned as follows*

*What this report will show …*

*Statements on Demographics – Context – The "Why"*

- *Aging population*
- *Loss of younger workforce*
- *Decrease in numbers in workforce*
- *Reflected in the health workforce*
- *State and nation (focus on state)*
- *Economic impact of health professions and health sector (where data is available)*

*Statements on Professions*

- *Which professions are addressed and why*

*Statements on how input was gathered*

- *Written statements*
- *Summit*

*Summary of findings/recommendations/conclusions*

## Background

*The Global Health Workforce Challenge*

The World Health Organization focused its 2006 World Health Report on the global health workforce. "Working Together For Health" describes significant disparities in health workforce among rich and poor nations not unlike the disparities we see in health care in general. While the populations of poorer nations go without even the most basic of health care services, the populations of wealthier countries enjoy a constant stream of newly discovered treatments and medications. Similarly, the populations of poorer nations cannot produce enough health care workers, and their "best and brightest" are often coaxed away to wealthier countries where greater personal and professional opportunities exist.

Iowa's health workforce decisions may not be directly impacted by global health concerns and will likely not strive to address them. However, these decisions are made in a climate of national and global shortages, and that point should be recognized. Iowa's population is in competition for health workers, not only with other states, but potentially with the rest of the world. What Iowa does to "grow its own" and prevent "brain drain" has significant impact on the state's ability to address its health workforce shortages.

*The National Health Workforce Challenge*

Over the next several decades, the increase in the population of Americans age 65 and over, and in those "oldest old" age 85 and over, will be dramatic. "The number of Americans age 65 and older (35 million in 2000) will rise by more than 19 million to 54 million by 2020. From 2000 to 2050, the number of older adults will increase from 12.5% to 20% of the U.S. population" (SUNY, 2006). Because older adults need and use more health care services than the general population, this increase will place significantly greater demand on the health care system. "Given changing health workforce demographics, looming retirements of health professionals, and increased demand for health services as the Baby Boomer generation ages, experts have estimated that the nation will need to produce 6 million new members of the health workforce by 2014 to replace retiring workers and fill new positions" (Moskowitz, 2007).

According to the Association of Academic Health Centers (2007), "Historically, states have been dedicated to educating and retaining residents to work within the state after graduation" (p. 3). But, since there is such an increasing demand on the health care system, states already find that they are not educating enough health professionals to meet their own state demand. Therefore, they recruit from other states and countries in an attempt to meet demand.

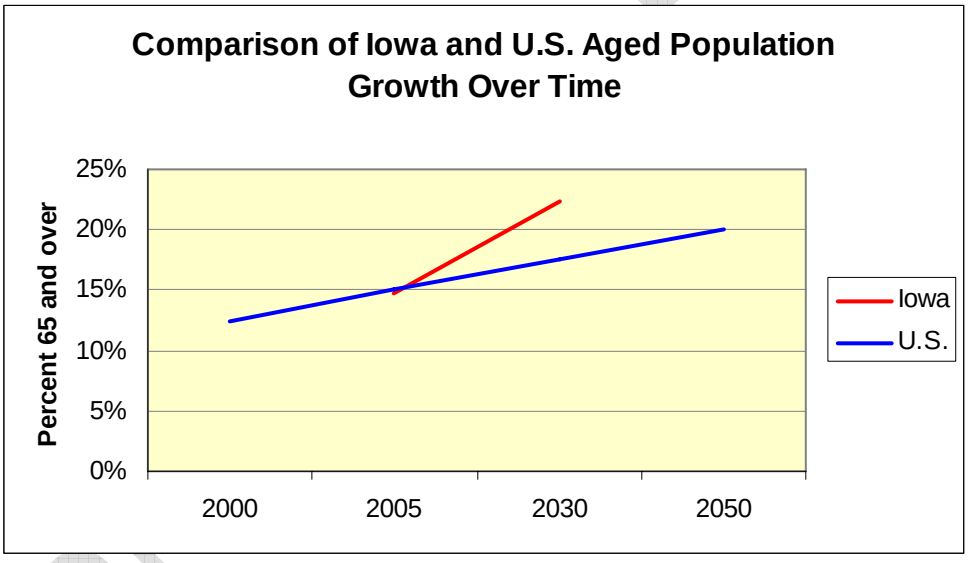
*Will build case for planning to address Iowa's needs via Iowa's educational institutions. Nation is short, so we can't rely on recruitment from other states to fill the need.*

*Will demonstrate how other states are acting to address their challenges and why Iowa needs to ramp up efforts to prevent good health care workers from leaving Iowa for better compensation/lifestyle/etc. in other areas of the country (i.e., build case for retention tools).*

*Iowa's Health Workforce Challenge*

Side bar
"State action on workforce issues is critical not only in resolving shortages but also in developing a workforce for the future." -- Association of Academic Health Centers

As we know, our population in Iowa is among the oldest in the nation. In 2005, 14.7 percent of Iowans were age 65 and over. It is projected that this population will grow to 22.4 percent of the state's total population by the year 2030. (State Data Center of Iowa …) Iowa's percentage increase in population age 65 and over will happen two decades faster than the rest of the nation!




By 2030, eighty-four Iowa counties will have 20% of their population over the age of 65. In 2000, only 30 counties had 20% of their population over the age of 65. (State Data Center of Iowa … )

Health Professional Shortage Areas (HPSAs) are federally-determined geographic areas, populations, or facilities which have fewer than a designated number of health professionals per population.

There are 214 Primary Care Health Professional Shortage Areas in Iowa. Thirty-eight counties are full or partial HPSAs. This means that the physician to population ratio in these counties is greater than 3,500:1 for a geographic HPSA or where the physician to population ratio is greater than 3, 000: 1, and at least 30% of the population is below 200% of the federal poverty level to qualify for a special population HPSA. The remainder of the HPSAs are facility designations that include Rural Health Clinics, Community Health Centers, correctional facilities and state hospitals. A facility designation means that the facility has a shortage of providers to serve the populations it exists to serve.

**2007 U.S. Department of Health and Human Services Federal Poverty Guidelines**

| Persons in Family or Household | 48 Contiguous States and D.C. | Alaska | Hawaii |
|---|---|---|---|
| 1 | $10,210 | $12,770 | $11,750 |
| 2 | 13,690 | 17,120 | 15,750 |
| 3 | 17,170 | 21,470 | 19,750 |
| 4 | 20,650 | 25,820 | 23,750 |
| 5 | 24,130 | 30,170 | 27,750 |
| 6 | 27,610 | 34,520 | 31,750 |
| 7 | 31,090 | 38,870 | 35,750 |
| 8 | 34,570 | 43,220 | 39,750 |
| For each additional person, add | 3,480 | 4,350 | 4,000 |

**SOURCE:** *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148

Forty-nine of Iowa's counties are Dental Health Professional Shortage Areas. There are 10 Geographic HPSAs in which the Dentist to population ratio exceeds 5,000:1. Thirty-nine Iowa counties are special population (low income and Medicaid) HPSAs with at least a 4,000:1 dentist to population ratio and the at least 30% of the populations is at or below 200% of the federal poverty level. It should be noted that if the requirement stating that at least 30% of the population must be at or below 200% of the federal poverty level did not exist, then 89 of the 99 Counties in Iowa would be designated.

Eighty-four of Iowa's counties are Mental Health Professional Shortage Areas. This means that there is at least a 20,000: 1 psychiatrist to population ratio within a designated "catchment area".

Most catchment areas contain multiple counties. Criteria for catchment areas are established according to section 238 of the Community Mental Health Centers Act.

Seven of the 20 occupations expected to grow in Iowa during the period from 2002 to 2012 are health care occupations. *(In the final report, we expect to be able to update this to include the professions expected to grow from 2004 to 2014.)*

Nursing and Residential Care Facilities along with Ambulatory Health Care Services are projected to be two of the top ten industries with the most job openings from 2002 to 2012. A third among the top ten is Social Assistance. Registered nurses are among the top ten occupations projected to incur the most annual openings within the same time period. (IWD … )

The variety of educational levels, time required for training, income levels, job mobility and other factors within the health workforce leads to a different discussion of supply, demand, recruitment and retention issues by profession. A theme that will be common, however, is that recruitment and retention in rural areas is and will become increasingly difficult. "Some of the most difficult recruiting in the United States today occurs in the health care sector, where labor shortages are acute, vacancy rates are high and the consequences of unfilled positions range far beyond those found in most industries. … …the health care labor shortage will become so acute over the next decade that greater recruiting efficiencies will not be able to breach the growing gap between supply and demand. Health care organizations will have to take a more aggressive collective approach at the national level to increase federal funding for training programs and substantially increase the size of the candidate pool" (Hansen, 2007).

**Iowa's Workforce Needs by Profession and Professional Groupings**

Within the health sector, there are a wide range of health professions. Due to time and budget constraints, this report cannot address each health profession separately. The professions and professional groupings listed in this report are those that seem, based on public input and research, to have emerged as areas of particular interest in Iowa. *Additional professions or professional groupings will appear in the final report if the summit on health workforce reveals them as areas that attendees believe should be included.*

*Direct Care*

"Seven out of ten elder services workers in long-term care is a paraprofessional, and at least eight out of every ten hours of paid services provided to an elder in non-acute settings is offered not by a doctor, nor a nurse, but by a paraprofessional worker" (Dawson, 2007).

Direct care workers, as defined by the Iowa Direct Care Worker Task Force, are individuals who provide "… services, care, supervision, and emotional support to people with chronic illnesses and disabilities. This definition does not include nurses, case managers, or social workers." (Iowa Direct Care Worker Task Force Report and Recommendations, page 9)

Direct care workers may perform a variety of tasks, "depending on the setting where the services are being provided and who is being served. People familiar with direct care services generally categorize them into three broad categories: environmental/chore, instrumental activities of daily living, and personal care." (Iowa Direct Care Worker Task Force Report and Recommendations, page 10.) Some job titles which may be included under the umbrella of the term "direct care worker" would include Certified Nurse Aid (CNA), Home Health Aid, Residential Care Aid, and others.

Settings where direct care workers provide services include, " … long-term care facilities (which includes nursing homes), residential care facilities, intermediate care facilities; hospitals; assisted living agencies; home care agencies; supported community living agencies; other community-based settings; and individual homes." (Iowa Direct Care Worker Task Force Report and Recommendations, page 25.)

For Iowa, two issues are perhaps the most striking and fundamental for understanding the challenge with direct care workforce. First, the demographic of an increasing number of people in need of direct care workers with a declining number of available workers. And, second, the high turnover within the direct care worker workforce.

*It is anticipated that further discussion about increasing demand and decreasing supply will be inserted here and that this discussion will include mention of the populations typically filling direct care worker vacancies and why those populations may be declining.*

*It is anticipated that discussion about the reasons for high turnover in the direct care field will be included here, which will likely include low wages, lack of respect/esteem for the profession, lack of a career track within the profession and potentially other issues.*

Direct care workers are among the lowest paid of health care workers and receive the most limited job-related benefits such as employer-paid health insurance. "Nearly one in four wage and salary workers and 25 and older living in rural (nonmetro) America in 2005 were low-wage workers" (Gibbs and Parker, 2007) as defined by living at 100% of the federal poverty level. Of these, one out of every 12 is a direct care worker. Because the long-term care industry is growing so quickly, that figure will become one in ten within ten years (Dawson, 2007). "Among all rural workers, low-wage workers are therefore more likely to participate in Federal assistance programs such as food stamps and school lunch programs as a means to ensure a measure of economic security" (Gibbs and Parker, 2007). *The final report will elaborate with discussion of lack of health insurance coverage for direct care workers.*

*Dental/Oral Health*

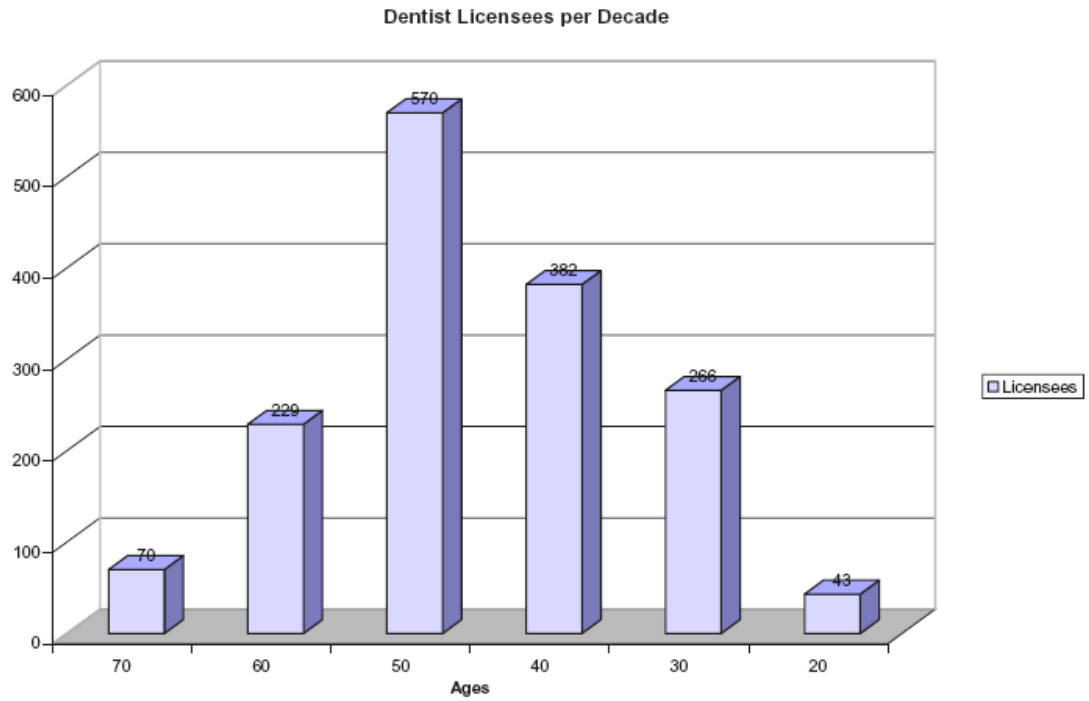
*It is anticipated that this section of the report will address both dentists and dental hygienists. It is further anticipated that additional research will be cited.*

Oral health directly affects the overall health and wellness of all Iowans. Oral disease is linked to preterm pregnancies, diabetes, cardiovascular disease, osteoporosis, brain-related abscesses, respiratory pneumonia in the elderly, and a growing number of other conditions.

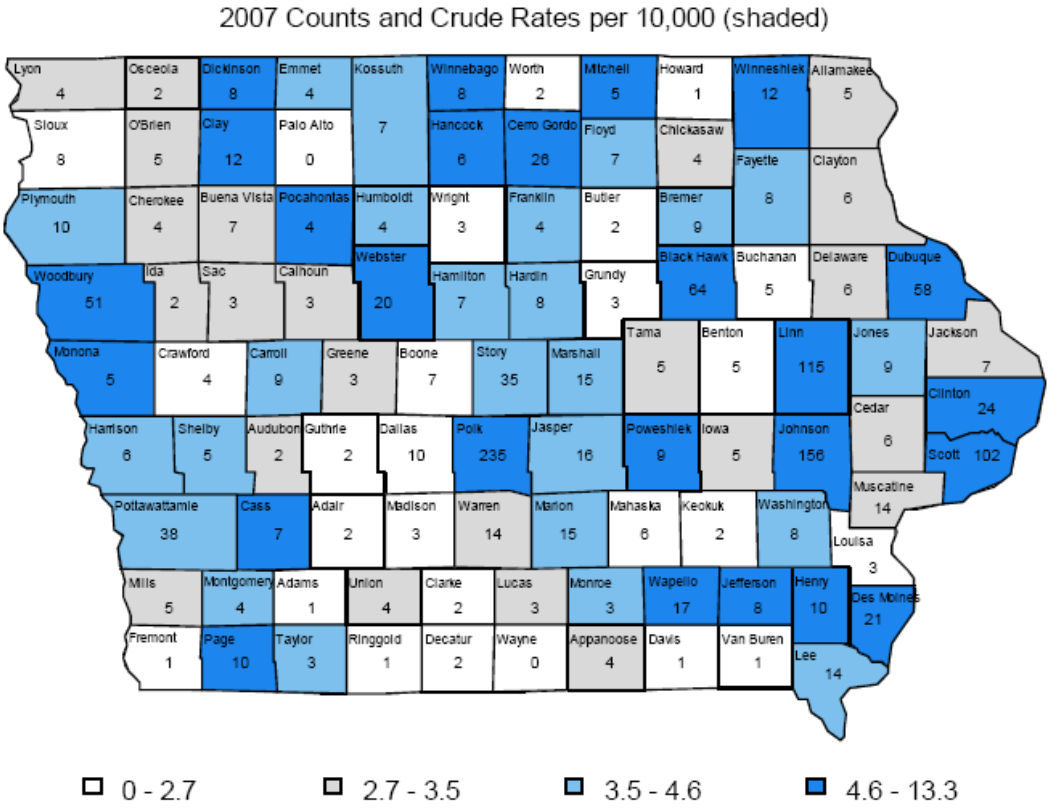
Low-income families face the greatest obstacles in getting oral health care. While 13% of all third graders in Iowa have untreated decay, the number is even higher for low-income children (18%). One-fourth of children do not have dental insurance to help pay for care. For children on Medicaid, 57% go without any dental services at all.

The challenges of getting vital oral health services and preventing disease can vary greatly due to many factors, including a lack of insurance coverage, lack of dental providers in rural areas, decreasing and aging dental health workforce, poor knowledge of proper oral hygiene and care, and public policies and programs which fail to provide incentives for dental professionals to provide care for underserved populations.

*The following page is an example of one-page visual summaries of workforce data by profession which the final report will include.*


Dentist Licensees per Decade
600
500
400
300
200
100
0
570
382
266
229
70
43
70
60
50
40
30
20
Ages
Licensees

## Dentists


2007 Counts and Crude Rates per 10,000 (shaded)
Lyon 4
Osceola 2
Dickinson 8
Emmet 4
Kossuth 7
Winnebago 8
Worth 2
Mitchell 5
Howard 1
Winneshiek 12
Allamakee 5
Sioux 8
O'Brien 5
Clay 12
Palo Alto 0
Hancock 6
Cerro Gordo 26
Floyd 7
Chickasaw 4
Fayette 8
Clayton 6
Plymouth 10
Cherokee 4
Buena Vista 7
Pocahontas 4
Humboldt 4
Wright 3
Franklin 4
Butler 2
Bremer 9
Woodbury 51
Ida 2
Sac 3
Calhoun 3
Webster 20
Hamilton 7
Hardin 8
Grundy 3
Black Hawk 64
Buchanan 5
Delaware 6
Dubuque 58
Monona 5
Crawford 4
Carroll 9
Greene 3
Boone 7
Story 35
Marshall 15
Tama 5
Benton 5
Linn 115
Jones 9
Jackson 7
Clinton 24
Cedar 6
Harrison 6
Shelby 5
Audubon 2
Guthrie 2
Dallas 10
Polk 235
Jasper 16
Poweshiek 9
Iowa 5
Johnson 156
Scott 102
Muscatine 14
Pottawattamie 38
Cass 7
Adair 2
Madison 3
Warren 14
Marion 15
Mahaska 6
Keokuk 2
Washington 8
Louisa 3
Mills 5
Montgomery 4
Adams 1
Union 4
Clarke 2
Lucas 3
Monroe 3
Wapello 17
Jefferson 8
Henry 10
Des Moines 21
Fremont 1
Page 10
Taylor 3
Ringgold 1
Decatur 2
Wayne 0
Appanoose 4
Davis 1
Van Buren 1
Lee 14
0 - 2.7
2.7 - 3.5
3.5 - 4.6
4.6 - 13.3

*Nursing*

An excellent summary of the current nurse workforce situation was provided in a recent Time.com article: "… The health-care system faces a deficit of as many as 1 million RNs by 2020. Yet American nursing programs turned away nearly 150,000 qualified applicants for all degree levels last year—including 38,415 from bachelor's programs—according to the National League for Nursing (NLN). The profession is trapped in a catch 22: hospitals, desperate for staff, poach nurses from one another with bonuses and perks. Nursing colleges can't fill the gap with new graduates because the schools can't compete in this overheated marketplace for the experienced nurses they need as teachers. 'Clinical salaries are so high that nurses don't want to leave for academia,' says NLN CEO Beverly Malone. 'But how do you train new nurses without teachers?'" (Kingsbury, 2007)

And the National Rural Health Association (NHRA, 2005) summarized the special challenges that rural areas face: "In rural areas, nursing shortages are exacerbated by the already difficult task of recruiting nurses coupled with rural employers' inability to compete with urban employers in terms of wages, start up bonuses and benefits that are offered. Non-acute health care settings fare the worst, in particular private practice settings, schools, health departments, extended care facilities and other community-based agencies that typically have even lower salaries than those offered by hospitals."

Finally, the Iowa situation was explained in these excerpts from the 2003 Issue Brief on Nursing Supply and Demand, Center for Health Workforce Planning, Iowa Department of Public Health:

> In 2000, the national supply of full-time equivalent registered nurses was estimated at 1.89 million while demand was estimated at 2 million, a shortage of 110,000 or 6 percent. The shortage is expected to grow relatively slowly until 2010 when it will have reached 12 percent. At that point, demand will begin to exceed supply at an accelerated rate, and by 2015, will have almost quadrupled to 20 percent. If not addressed, and if current trends continue, the shortage is projected to grow to 29 percent by 2020.
>
> Several factors are driving a growth in demand. These include an 18 percent increase in population, a larger proportion of elderly persons requiring more care, and medical advances that increase the need for nurses and nursing assistive personnel.
>
> In Iowa, the driving forces behind supply and demand reflect every national trend, including a high percentage of nurses who are approaching retirement, a diminished supply of new nurses and projections of over 2,000 RN vacancies at any point in time. Factors unique to Iowa include the following:
> - The economic challenges of a rural state with small, independent farming communities;
> - A declining population between the ages of 18 and 24;
> - A relatively high percentage of elderly Iowans with multi-system and accessibility needs;
> - A growing population of new Iowans employed in low income jobs who are not enrolling in nursing programs;

- A significant tuition and loan burden for students in pre- and post-licensure education programs;
- Low pay in the health fields related to reimbursement rates in Iowa;
- Departure of newly licensed registered nurses in pursuit of higher wages; and
- Aggressive recruitment of students and nurses by states experiencing acute shortages.

The United States Department of Labor ranks Iowa as the lowest paying state in the nation for registered nurses (May, 2007).

*A more complete discussion of nursing is expected for the final report. The advanced registered nurse practitioner (ARNP) level of nursing will be addressed including the consideration of a practice doctorate.*

*Mental Health*

Based on a May 2005 report (IDPH, 2005) which gathered data about the Iowa health professions most in need, Iowa's Center for Health Workforce Planning conducted a comprehensive examination of Iowa's mental health workforce in March 2006 (IDPH, 2006). It reported that the Health Resources and Services Administration (HRSA) had ranked Iowa 47th among states in psychiatrists per 100,000 population and 46th for psychologists per 100,000 population in 2000. In addition, the professions serving the mental health needs of Iowans exhibited the highest combined percentage of licensed professionals age 55 and older (approaching retirement). It concluded that Iowa is likely to lose a considerable number of experienced mental health professionals in the next ten years due to retirement.

As with other professions, the most rural areas of Iowa are among the most hard-hit by shortages in the mental health professions. The southern two tiers of counties and the northeast quadrant of Iowa have the fewest mental health professionals of all types. At the time of the Center's study, there were three mental health catchment areas with no psychiatrist at all. The need for child and adolescent psychiatrists is most acute in western Iowa. In a study conducted by Iowa's Critical Access Hospitals (CAHs), 72% of respondents deemed mental health services to be a key issue facing rural communities. That study identified reimbursement issues and lack of insurance coverage as primary factors affecting access to mental health services. Recruitment and retention of mental health workers were also important issues.

Iowa's legislature has already recognized and addressed some segments of the mental health workforce shortage. In House File 909 passed during the 2007 session, Iowa's legislature charged the Division of Mental Health and Disability Services with consulting with behavioral health workforce experts regarding implementation of the mental health and disability services training and the curriculum and training opportunities offered.

*It is anticipated that more information about legislation passed during the 2007 legislative session, particularly regarding administrators of community mental health centers and regarding psychologists will be included here. It is further anticipated that information about a*

*program at the Mental Health Institute in Cherokee to educate physician assistants for psychiatric care specialization and a program at the University of Iowa to educate advanced registered nurse practitioners for psychiatric care specialization will be inserted here.*

*Physicians*

"If we look at the economic impact of rural health care we find that for each additional 100 rural family physicians there is a $100 million per year impact on those rural communities. This impacts rural health care jobs and preserves rural health related facilities. Declines in rural physicians devastates education, population, and quality of life, thus reducing new jobs and local businesses. Once communities are affected by this economic impact, they have a tremendous uphill battle finding the resources to support a salaried practice that new graduates seek." National Rural Health Association, November 2006, pp. 3-4

A discussion of physician supply and demand holds many complexities. Physician supply and demand varies by specialty, including those specialties which are considered as "primary care", family medicine, general internal medicine (adult non-surgical), general pediatrics, obstetrics/gynecology, and geriatrics. Indeed, a full discussion of these issues would require an entire report focused only on physician supply and demand in Iowa. So, an attempt will be made to consolidate known high-level information here with the understanding that this information will be an overview.

Iowa faces difficulties with a maldistribution of physicians. While, for many areas of specialty, there are enough physicians in Iowa's urban areas, Iowa's rural areas are often short of the number of providers needed. This problem is not unique to Iowa. In fact, it is generally known that the physician who chooses to provide primary care in a rural area is becoming a rarity. The trend is for physicians to specialize and therefore choose more heavily populated areas which can support a specialty practice. Studies have shown that particular traits are common in those who choose primary care practice in rural areas. These doctors typically grew up in a rural area or are married to someone who grew up in a rural area. They also had an early interest in primary care practice in a rural area. Some type of experience with rural practice settings while in medical school has been found to be important as well (Wisconsin Medical Journal, 2007). In order for Iowa to address its need for physicians who practice in rural areas, the state will need to focus on finding and training the right individuals.

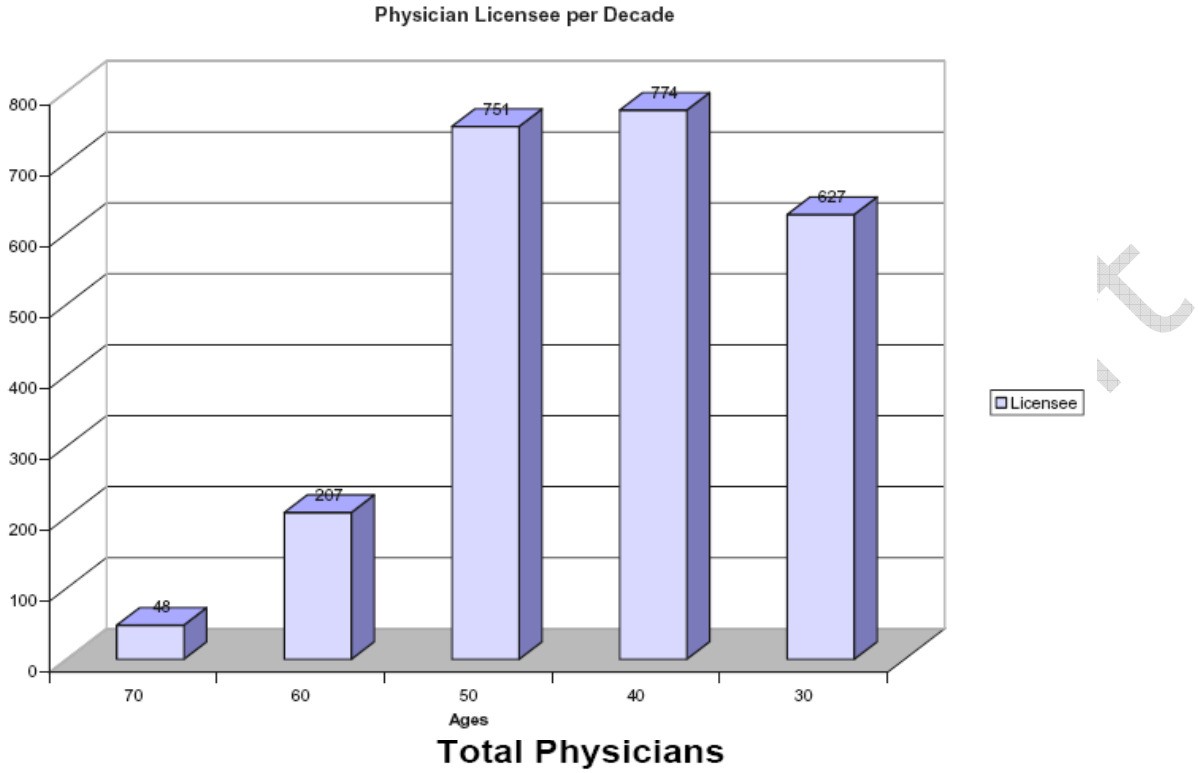
Iowa's physician supply has not gone unrecognized by those groups within the state who work extensively with physician professions. In December 2006, the Iowa Medical Society (IMS) presented information to the legislative Health and Human Services Appropriations subcommittee (Iowa Medical Society, 2006). This group cited Iowa as 44$^{th}$ in the nation in physicians per population. Recall that Iowa is 3$^{rd}$ in the nation in those age 65 and over, and the

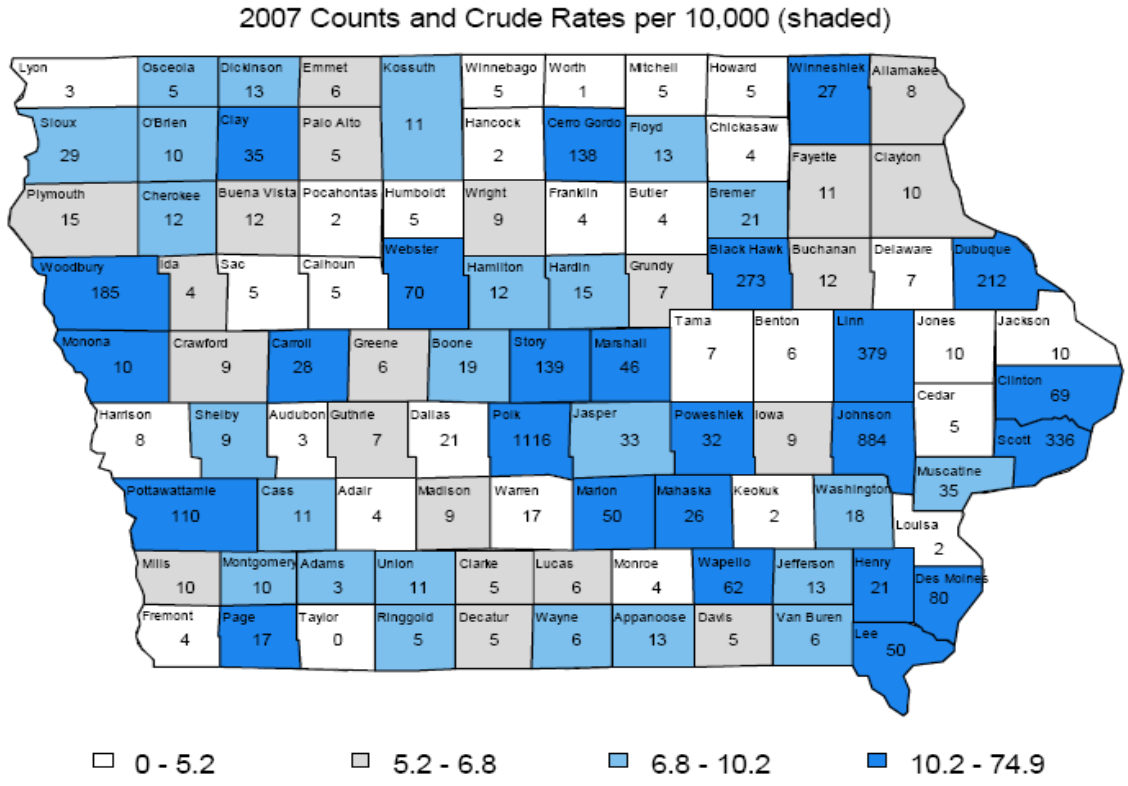
associated increased health needs of older citizens, and the disparity in these rankings alone is striking.

The University of Iowa Carver College of Medicine hosted the Task Force on the Iowa Physician Workforce, concluding with a final report published in January, 2007. This report focused on sorting out the intensity of the demand for various physician specialties in Iowa. The report provides various findings and recommendations.

The Iowa Association of Family Physicians has also initiated a study related to physician issues in Iowa, with data expected to be available in October, 2007 and a report expected to be available during the first part of 2008.

Like many states, Iowa uses a federal program referred to as the Conrad 30 J-1 Visa Waiver program to recruit International Medical Graduates (IMGs) to Iowa. Our state makes full use of this program, typically recruiting the maximum allowed number of doctors each year, and allowing needed specialty physicians to use the program, rather than restricting it to primary care physicians alone. Not all states use this maximum number of 30 doctors each year. The maximization of the program by the state of Iowa shows that there is a significant and ongoing need and difficulty in finding physicians who want to practice in needed specialties and geographic areas in Iowa.


Physician Licensee per Decade
800
700
600
500
400
300
200
100
0
48
207
751
774
627
70
60
50
40
30
Ages
Licensee
Total Physicians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Allamakee 8
Sioux 29
O'Brien 10
Clay 35
Palo Alto 5
Hancock 2
Cerro Gordo 138
Floyd 13
Chickasaw 4
Fayette 11
Clayton 10
Plymouth 15
Cherokee 12
Buena Vista 12
Pocahontas 2
Humboldt 5
Wright 9
Franklin 4
Butler 4
Bremer 21
Webster 70
Black Hawk 273
Buchanan 12
Delaware 7
Dubuque 212
Woodbury 185
Ida 4
Sac 5
Calhoun 5
Hamilton 12
Hardin 15
Grundy 7
Tama 7
Benton 6
Linn 379
Jones 10
Jackson 10
Monona 10
Crawford 9
Carroll 28
Greene 6
Boone 19
Story 139
Marshall 46
Clinton 69
Cedar 5
Harrison 8
Shelby 9
Audubon 3
Guthrie 7
Dallas 21
Polk 1116
Jasper 33
Poweshiek 32
Iowa 9
Johnson 884
Scott 336
Muscatine 35
Pottawattamie 110
Cass 11
Adair 4
Madison 9
Warren 17
Marion 50
Mahaska 26
Keokuk 2
Washington 18
Louisa 2
Mills 10
Montgomery 10
Adams 3
Union 11
Clarke 5
Lucas 6
Monroe 4
Wapello 62
Jefferson 13
Henry 21
Des Moines 80
Fremont 4
Page 17
Taylor 0
Ringgold 5
Decatur 5
Wayne 6
Appanoose 13
Davis 5
Van Buren 6
Lee 50
0 - 5.2
5.2 - 6.8
6.8 - 10.2
10.2 - 74.9

*Public Health*

"The most difficult challenge state and local public health agencies face in developing the capacity to respond to terrorist events, emerging infectious diseases, and other public health threats and emergencies is assuring a qualified workforce is available to carry out these functions. If current workforce demographic trends are left unchecked, they will have an adverse affect on the capacity of state health agencies to carry out their mission; including responsibilities that have continued to expand since the events of September 11, 2001, and the ensuing anthrax attacks" (Association of State and Territorial Health Officials, 2004).

The following is an excerpt of findings included in a study completed by the National Center for Health Workforce Analysis in January, 2005:

- The single biggest barrier to adequate staffing of governmental public health agencies was budget constraints.
- Public health agencies in all six States [studied] reported difficulty recruiting public health nurses (PHNs), especially in rural areas, but less difficulty retaining them.
- Public health physicians and dentists comprise a very small part of the public health workforce; they can be hard to recruit when vacancies arise, particularly in rural areas.
- In addition to the difficulty they experienced recruiting public health nurses and to a lesser extent, physicians and dentists, governmental public health agencies in the case study States reported difficulty recruiting for a variety occupations, including:
    - health educators,
    - nutritionists,
    - social workers,
    - clerical staff,
    - epidemiologists,
    - dental hygienists,
    - dental assistants,
    - laboratory personnel, and
    - home health aides.
- Beyond budget constraints, recruitment difficulties were attributed to general shortages of workers within an occupation (e.g., registered nurses, nutritionists), non-competitive salaries, and lengthy processing time for new hires.
- Rural public health agencies in most States reported drawing their staff from the local labor market and had more difficulty recruiting more educated, skilled public health workers than their urban or suburban counterparts.

While these reports comment on the impact of workforce shortages on the discipline of public health, other factors also impact this discussion. Public health agencies at state and local levels are also in wide-ranging discussions about accreditation standards, striving for a consistent level of public health services across state and local boundaries. The need for establishing these standards puts even greater emphasis on Iowa's need to address its supply of health workers, including those with training not only in the basics of their professions but also with specialized

training in public health. *(The Iowa Public Health Standards may appear as an appendix to the final report.)*

*Other Health Professions*

*The final report will include background research and supply and demand information about additional health professions as deemed necessary by input from various stakeholders including members of the Commission on Affordable Health Care for Small Business and Families, state agency partners engaged with IDPH in this project, health workforce summit attendees and others as appropriate.*

## Recommendations for Iowa

*Recommendations will be added following the completion of a health and long-term care workforce summit to be held on November 9, 2007. Prior to the summit, written input will be gathered from stakeholders and reviewed and consolidated by IDPH staff. The summit will facilitate discussion of the written input with the goal of reaching consensus among stakeholders regarding action steps for the future. These consensus results will be included in this section of the final report.*

## Recommended Action Steps for the Near Term (1-2 years)

***Note: The numbering of action steps is solely to facilitate easy discussion. It does NOT indicate a priority order.***

**Overall**

1.

**Direct Care**

2.

**Mental/Behavioral Health**

3.

**Nurse**

4.

**Oral/Dental Health**

5.

**Physician**

*The vitality of the economy affects the demand and use of physician services.* Multiple studies by health economists have shown that the growth of the health sector, including physician services, is directly tied to overall economic growth. Health spending in general and spending on physician services in particular are closely related to the growth of the economy." (Richard A. Cooper, M.D., Director of the Health Policy Institute of the Medical College of Wisconsin, presentations to members of the American

Association of Medical Colleges, 2005-2006 as cited in the Report of the Task Force on the Iowa Physician Workforce, January 2006, UI Carver College of Medicine, p.6.)

6.

**Other Professions**

7. *(It is anticipated that written and summit input will result in other health and long-term care professions emerging as priorities for Iowa. Additional headings for those professions will be added to this section of the report as indicated via the input.)*

## Recommended Action Steps for the Long-Term (2-5 years)

***Note: Action steps are numbered to make conversation about the recommendations easier, but the numbering does NOT indicate a priority order.***

**Overall**

8.

**Direct Care**

9.

**Mental/Behavioral Health**

10.

**Nurse**

11.

**Oral Health**

12.

**Physician**

13.

14.

## Other Professions

15. *(It is anticipated that written and summit input will result in other health and long-term care professions emerging as priorities for Iowa. Additional headings for those professions will be added to this section of the report as indicated via the input.)*

## References

*As the final report is compiled, IDPH will add all references used to the right hand column of the table below. The final report will include corrected and edited citations. It will be sorted in alphabetical order, and the left column will be used to number the references so that citations in the body/test of the report can be marked with superscript to allow for easier reading.*


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Iowa Workforce Development. 2012 Statewide Iowa Job Outlook. http://www.iowaworkforce.org/lmi/occupations/outlook/joboutlookstate.pdf

Iowa Workforce Development and U.S. Census Bureau. (May, 2006) Iowa Older Worker Profile. http://www.state.ia.us/elderaffairs/Documents/OlderWorkerBrochureStats06.pdf

The Iowa Health Fact Book. (2007) http://www.public-health.uiowa.edu/factbook/

National Rural Health Association. Recruitment and Retention of a Quality Health Workforce in Rural Areas: A series of Policy Papers on The Rural Health Careers Pipeline Number 1: Physicians (November, 2006) http://www.nrharural.org/advocacy/sub/issuepapers/Physician-1.pdf

Iowa Medical Society. December, 2006. Presentation to the Iowa Legislative Subcommittee on Health and Human Services Appropriations. http://www.legis.state.ia.us/lsadocs/SC_MaterialsDist/2007/SDSLL049.PDF

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National Center for Health Workforce Analysis. U.S. Department of Health and Human Services, Bureau of Health Professions. January, 2005. Public Health Workforce Study.
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http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf

Iowa Department of Public Health, Bureau of Health Care Access, Center for Health Workforce Planning. May, 2005. A Report Prioritizing a Shortage of Licensed Health Professionals in Iowa.
http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf

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U.S. Department of Labor. (May, 2007) Highest and lowest paying states by selected occupations. http://www.bls.gov/news.release/ocwage.t06.htm

**Appendix #A#**

## Additional sources of Iowa Health Workforce Data and Analysis

*While the topic of health and long-term care workforce is very broad, the final report will attempt to remain concise. There are many valuable existing sources of data and statistics regarding Iowa's health and long-term care workforce. It is anticipated that while not all of these sources will be used as formal references for this report, they will be addressed in some format so that readers can easily access additional pertinent data as needed. It is further anticipated that the report would categorize these resources by subject matter.*

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|---|---|
| Hospital Workforce | Health Professional Work Force Survey Trends: Trend Analysis of Hospital-Based Health Workforce, Iowa Hospital Association, April 2007 http://www.ihaonline.org/infoservices/workforcetrend/2007%20Workforce%20Survey%20Trend%20Analysis.pdf |
| Physician Workforce | • Presentation to the Health and Human Services Appropriation Subcommittee of the Iowa Legislature by Iowa Medical Society, December 2006 http://www.legis.state.ia.us/lsadocs/SC_MaterialsDist/2007/SDSLL049.PDF<br>• Report of the Task Force on The Iowa Physician Workforce, University of Iowa Carver College of Medicine, January 2007 http://www.healthcare.uiowa.edu/CCOM/Administration/IowaPhysicianWorkforce.pdf |
| Workforce, All | U.S. Bureau of Labor Statistics on-line Industry-Occupation Employment Matrix allows look-up of 10-year projections by occupation and industry. http://data.bls.gov/oep/nioem/empiohm.jsp |
| Health Professional Shortage Areas (HPSAs) | The U.S. Department of Health and Human Services, Health Resources and Services Administration includes HPSA criteria on its Web site: http://bhpr.hrsa.gov/shortage/ |

**Appendix #B#**

## Summary of Input from State Agency Collaborators

*IDPH has gathered input from state agencies. This input will be summarized as an appendix to the report.*

**Appendix #C#**

## Summary of Input Received at Health Workforce Summit

*While emergent results will be included in the body of the report, it is anticipated that a more detailed record of results will also be included as an appendix. In the event that there are dissenting opinions regarding recommended action steps, an attempt will be made to count and reflect the differences of opinion in the appendix so that stakeholders and those reading the report have an ability to discern the amount of controversy or dissention that may exist regarding any given recommendation.*